Billing for Medicaid-Eligible Members

The CMO will determine the reimbursement rate for the services included in the Family Care benefit package, if the CMO authorizes payment for the services.

Billing for Services Included in the Family Care Benefit Package

Providers should bill the Care Management Organization (CMO) for services included in the Family Care benefit package. Each CMO will determine the policies and procedures for billing services, including:

- Claim form and coding requirements.
- Billing deadlines.
- Coordination of benefits (commercial health insurance and Medicare).

Contact the appropriate CMO for more information on the required billing procedures. Refer to Appendix 1 of this guide for a list of CMO contacts.

The CMO will determine the reimbursement rate for the services included in the Family Care benefit package, if the CMO authorizes payment for the services. Care Management Organizations may not reimburse providers at rates higher than the Medicaid rate for Medicaid services included in the Family Care benefit package.

Wisconsin Medicaid fee-for-service will not reimburse providers for services included in the Family Care benefit package. An explanation of benefits code will appear on the provider's Remittance and Status Report, indicating Wisconsin Medicaid has denied the service because the member is enrolled in a Medicaid managed care program.

Medicare Crossover Claims

When a provider first bills Medicare for services included in the Family Care benefit package:

1. The provider sends the claim to Medicare, using existing Medicare billing guidelines.
2. If a member has both Medicare and Medicaid coverage, the claim will process through the Medicare claims system, then may cross over to Medicaid fee-for-service.
3. Medicaid fee-for-service will deny all charges for services included in the Family Care benefit package.
4. The provider is responsible for following the appropriate CMO's billing instructions for consideration of Medicare's coinsurance and deductible.

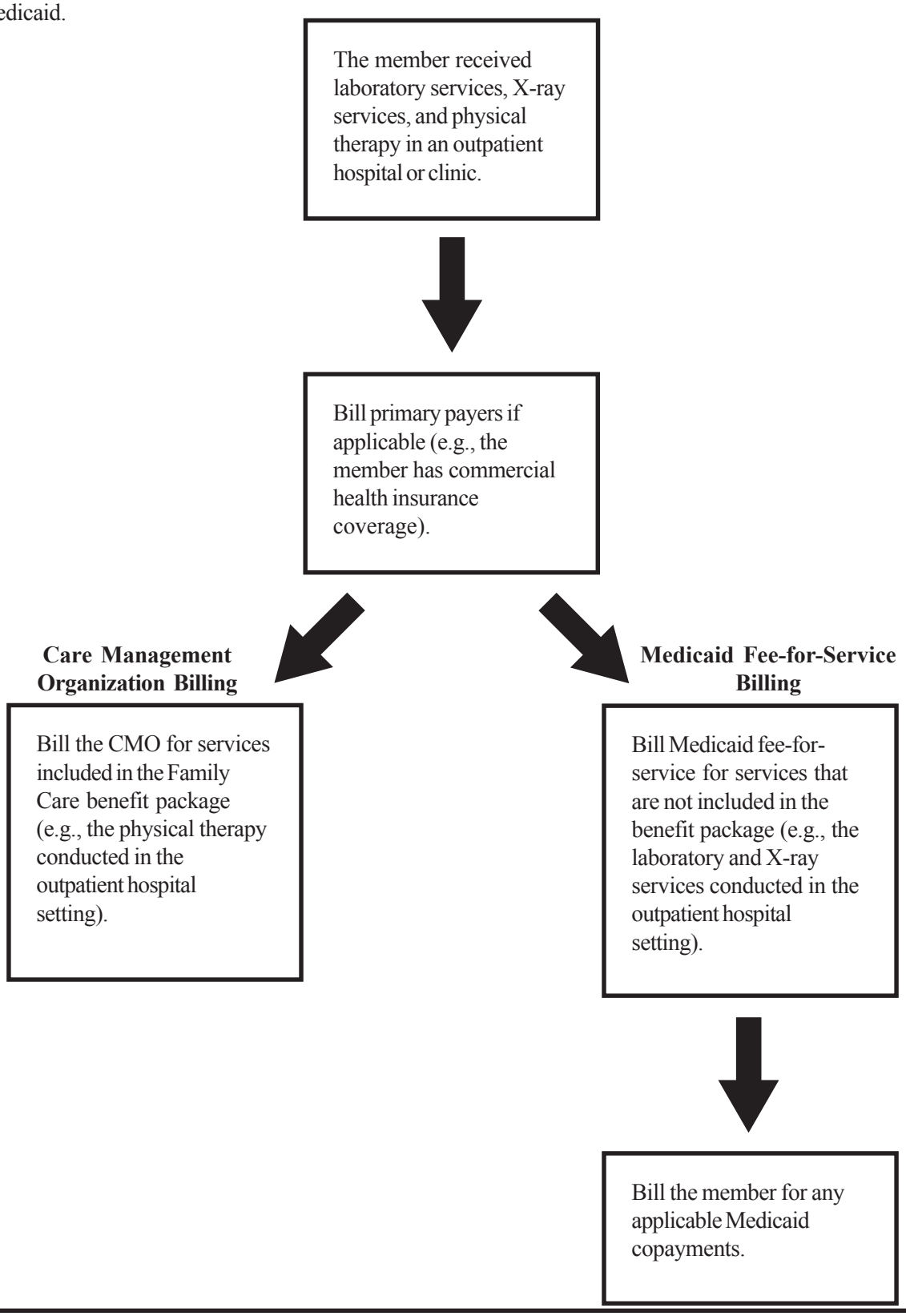
Providers should bill Medicare prior to billing the CMO to obtain the necessary payment or denial information from Medicare. However, providers do not need to wait for Medicaid fee-for-service to deny a claim before billing the CMO for services included in the Family Care benefit package.

Billing for Medicaid Services Not Included in the Family Care Benefit Package

Providers should bill Wisconsin Medicaid fee-for-service for Medicaid-covered services that are not included in the Family Care benefit package when provided to Medicaid-eligible members. Providers are required to follow all Medicaid fee-for-service policies, including policies for prior authorization and for billing primary payers (e.g., Medicare or other insurance) prior to billing Medicaid.

Split Billing Example for Medicaid-Eligible Members

The following chart illustrates a split billing situation, which occurs when the provider is required to bill both the CMO and Medicaid fee-for-service for services provided to a member. The example assumes the member is eligible for both Family Care and Medicaid.



Refer to the All-Provider Handbook and your service-specific handbook for more information on billing services to Wisconsin Medicaid.

Split Billing

Services included in the Family Care benefit package **do not** require a recipient copayment.

Providers may need to produce two separate bills for services provided to a Medicaid-eligible CMO member. This occurs when one service is included in the Family Care benefit package and another service is not included in the Family Care benefit package, but is covered by Medicaid fee-for-service.

When this occurs:

- Bill Medicaid fee-for-service for services that are not included in the Family Care benefit package (e.g., outpatient hospital lab and X-ray services).
- Bill the appropriate CMO for services included in the Family Care benefit package (e.g., outpatient hospital physical therapy, the nursing home daily rate for room and board agreed to in the CMO contract).

Refer to the chart on the previous page for an illustration of a split-billing situation.

Member Payment for Services

Copayment

Services included in the Family Care benefit package **do not** require a recipient copayment. However, Medicaid services that are *not* included in the Family Care benefit package require the applicable Medicaid recipient copayment. Refer to the Recipient Rights and Responsibilities section of the All-Provider Handbook for more information on Medicaid fee-for-service copayment.

Member Cost-Share

As outlined in the Member Information chapter of this guide, the financial eligibility assessment determines if a CMO member is required to pay a monthly cost-share. The monthly cost-share is based on the member's income and assets and his or her monthly cost of care. The CMO may collect the cost-share amount or direct a specific provider to collect the amount.

Family Care cost-share ***is not*** the same as Medicaid spenddown.

Medicaid Nursing Home Resident Liability

If a Medicaid-eligible member is residing in a nursing home and enrolls in Family Care, the individual will no longer be responsible for a Medicaid nursing home liability amount. Instead, when the individual is enrolled in a CMO, the individual:

- Will only pay the Medicaid nursing home resident liability for the current month.
- Will pay his or her cost-share beginning the next month.

The same policy applies when an individual enrolls in a CMO mid-month.

Provider Appeals

Both providers who are affiliated and providers who are not affiliated with a CMO may file an appeal when they disagree with the CMO's payment/denial determination.

When a CMO denies a provider's claim, the CMO is required to send the provider a notice describing the appeal process, including specific deadlines which must be met at various points in the process. The CMO is also responsible for supplying the provider with instructions on filing an appeal with that CMO. Providers are required to file their first appeal to the CMO within 60 days of the initial payment/denial notice. The CMO has 45 days from the date of receipt of the appeal request to respond in writing to the provider.

If the CMO fails to respond within the 45-day time frame, or if the provider is not satisfied with the CMO's response, the provider may

seek a final determination from the Department of Health and Family Services (DHFS). If the CMO does respond within the 45-day time frame, the provider has 60 days from receipt of the CMO's response to file the appeal to the DHFS.

The DHFS has 45 days from the date of receipt of written appeals to make a decision. The DHFS' decision is final. The CMO is required to pay the provider within 45 days of the DHFS' decision, if applicable.

Refer to Appendix 3 of this guide for a list of CMO and DHFS provider appeal contacts.